KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
DIVISION OF DISABILITY & BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH SERVICES

Residential Care Facility License Application

Complete entire application and all attachments, then return the original and one copy to your local SRS Area Office, Attention: Mental Health Facility Quality Improvement Field Staff. If this is a renewal of a current license, application must be returned **at least 60 but not more than 90 days** before the expiration date of the current license. If this is an application for a new license, application must be returned **at least 90 days before the desired date of licensing**.

Facility Name:	Facility Address:
Facility Phone #: ( )	Desired Licensing Start Date:
Federal Employer ID #:	Operator's Name:
Operator's Address:	Operator's Phone #: ( )
Requested Capacity:	# Residents Currently in Facility:

List all staff member's names, social security #s, and job titles, and indicate which are First Aid certified, and when the certification date(s) expire(s):

List two persons unrelated to you who may be used as references:

NAME	ADDRESS	PHONE #
		( )
		( )

Are you or any member of your staff presently charged with or on probation or parole for a crime?
___ Yes ___ No If yes, please explain:

Have you or any member of your staff been convicted of child or adult abuse, child or adult neglect, or sexual offense? ___ Yes ___ No If yes, please explain:

NOTE: A conviction does not necessarily exclude approval of facility licensure, but may necessitate an inquiry by a Mental Health Field Staff.

REQUIRED ATTACHMENTS

Attach to this application:

1. A floor plan of the facility which includes the sizes and uses of each room (this is required for ALL applications, initial and renewal).
2. A narrative which briefly describes the care which will be provided by the facility staff for the residents (this is required for ALL applications, initial and renewal).
3. Copies of KBI Background Checks on all current employees, including facility owner(s) (initial applications only).

ASSURANCES:

1. The facility agrees to maintain current information on this application and the attachments as changes occur by notifying this State Department of Social and Rehabilitation Services in Writing.

2. The facility agrees not to exclude any person from employment or from services for reasons of age, sex, handicap, race, religion, color, ancestry, or national origin.

3. To my knowledge, no member of the staff has been convicted of corporal punishment, physical, mental, and/or emotional abuse, or a sexual offense unless otherwise stated on page one (1).

4. The facility agrees to restrict any employee from work during the time that the employee has a communicable disease.

5. As (an) authorized person(s) of the facility, we/I have read the laws and regulations governing the operation of this facility and it is our/my intention to comply insofar as possible and to cooperate with the State Department of Social and Rehabilitation Services. We/I further certify that the information on this application is complete and accurate to the best of our/my knowledge.

_____

Signature of Authorized Individual Title Date

_____

Signature of Authorized Individual Title Date

NOTE: The Department of Social and Rehabilitation Services will process completed applications within sixty days after it has been received and the prerequisites in 30-42-10 have been satisfied.